

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2010
NAME OF PROVIDER OR SUPPLIER HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>An annual Recertification survey and complaint investigation #'s 24625, 24900, 26737, were completed at Holston Manor, on October 25 - 27, 2010. No deficiencies were cited under 42 CFR Part 483, Requirements for Long Term Care Facilities related to the complaint investigations.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p> <p><u>F-225 Comprehensive Care Plans</u></p> <ol style="list-style-type: none"> Investigation of alleged incident reported to Surveyor on 10/27/10 was completed on 11/4/2010. Investigation substantiated inappropriate transfer of resident. All residents have the potential to be affected by the same deficient practice. Staff will be inserviced on our Abuse Policy and Incident Investigation Procedures by the Risk Manager and/or Social Services. Completion date: 11/30/10 Social Services and/or Risk Manager will randomly interview alert and oriented residents to ensure the deficient practice will not recur. (Interview schedule: 5 residents per week x 2 weeks, 2 residents per week x 2 weeks, for a total of 4 weeks.) Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. Completion date: 11/30/2010 	11/30/10
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark de Fluiter</i>			TITLE Administrator	(X6) DATE 11/11/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to investigate an incident of unknown origin for one resident (#5) of thirty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on November 16, 2009, with diagnoses including Amputation Below Knee (Right), Muscle Weakness, Diabetes Mellitus II, Late Effects Cerebrovascular Disease, Congestive Heart Failure, Dysphagia, Rehabilitation, Physical Therapy, Pace Maker, Coumadin Alert, Abnormal Gait, and Renal Failure.</p> <p>Medical record review of the Minimum Data Set (MDS) dated October 24, 2010, revealed the resident was alert and oriented, non ambulatory, and required assistance with all activities of daily living. Continued review of the MDS revealed the resident was able to understand and was able to be understood.</p> <p>Observation on October 25, 2010, at 7:35 p.m., revealed the resident in a specialty bed, awake, alert and able to communicate appropriately. Continued observation revealed the resident with a below knee amputation of the right leg.</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>Interview with the resident during the observation revealed the resident had an open area on the left lower extremity. When the resident was asked the origin of the open area, the resident stated, "(staff) was rough when putting back in bed and skinned the leg."</p> <p>Medical record review of a Wound/Healing Record dated June 21, 2010, revealed "Stage II, 3 x 1 cm. (centimeters), open area, left (lower) leg, pink-beefy red, surrounding skin color - pink." Continued medical record review of the Wound/Healing Record dated October 21, 2010, revealed the description of the wound as "4.5 x 2.0 cm., Slough-Black/Brown (Eschar)."</p> <p>Medical record review of a hospital report dated June 28, 2010 revealed "left calf skin tear."</p> <p>Observation with the Assistant Director of Nursing and the Wound care nurse and interview with the resident, on October 27, 2010, at 9:30 a.m., revealed the resident confirmed a staff member had been rough when putting the resident back to bed, and did not use the lift as requested by the resident. Continued interview revealed the resident stated "(staff) threw me in the bed like a sack of potatoes, two or three months ago."</p> <p>Observation with the Nurse Practitioner, and interview with the resident on October 27, 2010, at 10:00 a.m., revealed the resident restated the same thing happened to the leg, two or three months ago.</p> <p>Interview with the Director of Nursing on October 27, 2010, at 3:00 p.m., in the administrator's office, confirmed an investigation had not been completed regarding the skin tear and</p>	F 225			

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F 225	Continued From page 3	F 225			
F 281 SS=D	<p>development of the open area on the resident's lower left leg.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to monitor one resident (#24) during a medication administration of thirty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #24 was admitted to the facility on October 11, 2010, with diagnoses including Senile Dementia, Alzheimer's disease, and Asthma.</p> <p>Medical record review of the Minimum Data Set dated October 18, 2010, revealed the resident had short and long term memory impairment and moderately impaired decision making skills.</p> <p>Medical record review of the Physician's Orders dated October 12, 2010, revealed, "...Proventil (albuterol) per unit dose...Q (every) 6 (six) HRS (hours)...Atrovent (ipratropium Bromide 0.2 %) per unit dose...Q (every) 6 (six) HRS (hours)..."</p> <p>Observation on October 26, 2010, at 7:56 a.m., revealed the resident was receiving a nebulizer treatment via a nebulizer mask which was placed over the resident mouth and no facility staff in the room.</p>	F 281	<p><u>F-281 Professional Standards</u></p> <ol style="list-style-type: none"> 1. Nurse received a documented written performance improvement plan on 10/26/2010. 2. All residents who have physician orders for nebulizer treatments have the potential to be affected by the same deficient practice. 3. Licensed nurses will be inserviced on the proper procedure for nebulizer treatments by the Director of Nursing and/or Risk Manager. Completion date: 11/30/2010 4. RN Supervisors and/or Admission Nurse will randomly perform Medication Pass Evaluations. (Medication Pass Schedule: 6 med passes per week x 2 weeks, 3 med passes per week x 2 weeks for a total of 4 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. Completion Date: 11/30/2010 		11/30/10

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F 281	Continued From page 4 Interview with Licensed Practical Nurse (LPN) # 1 at the 600 hall nurse's desk, on October 26, 2010, at 7:59 a.m., revealed the charge nurse placed the nebulizer mask; turned the nebulizer machine on; placed the Proventil and Atrovent inside the plastic cylinder attached to the nebulizer mask and left the room. Interview with the Director of Nursing (DON) outside the DON's office, on October 26, 2010, at 8:10 a.m., confirmed the facility failed to monitor the resident while medications were administered through a nebulizer machine.	F 281			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of manufacturer's specifications, and interview, the facility failed to prevent medication errors less than five percent resulting in six errors within fifty-two opportunities to equal an error rate of eleven percent. Observation revealed errors occurred with four (#1, #2, #3, #4) of four nurses, five (100 Hall, 200 Hall, 300 Hall, 400 Hall #1 and 400 Hall #2) of six medication carts, and five (#31, #32, #33, #34, #35) of six residents observed. The findings included: Medication Error #1	F 332	<u>F-332 Free of Medication Error Rates of 5% or More</u> 1. Medication Error Reports were completed for all six errors by the RN Supervisors. No adverse reactions related to the above errors. Completion Date: 10/27/2010 2. Residents who have physician orders for histamine-2 blockers, sliding scale insulin, corticosteroid inhalers, and guaifenesin have the potential to be affected by the same deficient practice. 3. Residents on histamine-2 blockers and sliding scale insulin will have a medication review by the Pharmacy Consultant and/or Director of Nursing to ensure compliance with manufacture's specifications. Licensed Nurses will be inserviced on correct medication administration and following manufacture's specifications. Completion Date: 11/30/2010 4. RN Supervisors and/or Admission Nurse will randomly perform Medication Pass Evaluations. (Medication Pass Schedule: 6 med passes per week x 2 weeks, 3 med passes per week x 2 weeks for a total of 4 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary. Completion Date: 11/30/10	11/30/10	

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F 332	<p>Continued From page 5</p> <p>Observation on October 25, 2010, at 7:00 p.m., at the 100 Hall Cart, revealed Licensed Practical Nurse (LPN) #1 administered one Famotidine 20 mg (milligram) tablet for Gastroesophageal Reflux Disease (GERD) to resident #31.</p> <p>Medical record review of the signed physician orders dated October 4, 2010, for resident #31 revealed an order for "...PEPCID (FAMOTIDINE) 20 MG PO (by mouth) Q (every) 6 AM & 6 PM (GERD)..."</p> <p>Review of the manufacturer's specification for Famotidine in the Geriatric Dosage Handbook Fourteenth Edition Page 622 under patient information revealed "...Take with or immediately after meals..."</p> <p>Interview with LPN #1 on October 25, 2010, at 8:40 p.m., at the 100 Hall Nursing Station, confirmed one medication error occurred when the Famotidine 20 mg tablet was not administered with or immediately after a meal.</p> <p>Interview with the Nutritional Service Manager on October 26, 2010, at 12:45 p.m., in the Director of Nursing (DON) office confirmed the dinner trays for the 100 Hall are served between 5:20 p.m., and 5:35 p.m., daily. The Famotidine 20 mg tablet was administered to resident # 31 approximately 90 minutes after dinner was served.</p> <p>Medication Error #2</p> <p>Observation on October 25, 2010, at 7:52 p.m., at the 100 Hall Cart, revealed LPN #1, after recording a blood glucose level of 211, administered subcutaneously 6 units of Novolin R Insulin 100 units/ml (milliliter) for an elevated</p>	F 332			

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F 332	<p>Continued From page 6</p> <p>blood sugar in the upper right abdomen of resident #32.</p> <p>Medical record review of the signed physician orders dated October 4, 2010, for resident #32 revealed an order for "...S.S. (Sliding Scale) Insulin #2 Novolin R...inject 201-250=6 UT (units)..."</p> <p>Review of the manufacturer's specification in the Novolin R package insert under Dosage and Administration revealed "...The injection of Novolin R should be followed by a meal within approximately 30 minutes of administration..."</p> <p>Interview with LPN #1 on October 25, 2010, at 8:40 p.m., at the 100 Hall Nursing Station, confirmed one medication error occurred when the dose of Novolin R insulin injection was administered after the dinner tray was served.</p> <p>Interview with the Nutritional Service Manager on October 26, 2010, at 12:45 p.m., in the DON office confirmed the dinner trays for the 100 Hall are served between 5:20 p.m., and 5:35 p.m., daily. The SS Novolin R injection was administered two hours after the dinner meal was served.</p> <p>Medication Error #3</p> <p>Observation on October 26, 2010, at 7:26 a.m., at the 400 Hall Cart #1, revealed LPN #2 administered one puff of QVAR (Beclomethasone D 80 microgram dose) for COPD (Chronic Obstructive Pulmonary Disease) by oral inhalation and after five minutes administered another puff to resident #33.</p>	F 332			

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F 332	<p>Continued From page 7</p> <p>Further observation revealed Resident #33 swallowed one glass of water after the administration of the two puffs of the QVAR inhaler.</p> <p>Medical record review of the signed physician orders dated October 7, 2010, for resident #33 revealed an order for "...QVAR 7.3 GM CT (container) 2 PUFFS INHALE Q 12 HRS (hours) (COPD)..."</p> <p>Review of the manufacturer's specification in the Inhaled Medications guide from the American Society of Consultant Pharmacists (MED-PASS) revealed under Corticosteroid (QVAR) Inhalers to "...Rinse mouth after each use (do not swallow the rinse water) to help prevent oropharyngeal fungal infections..."</p> <p>Interview with LPN #2 on October 26, 2010, at 8:10 a.m., outside the room of resident #33 on the 400 Hall, confirmed one medication error occurred when the resident swallowed the glass of water after the administration of two puffs of QVAR.</p> <p>Medication Error #4</p> <p>Observation on October 26, 2010, at 8:23 a.m., at the 300 Hall Cart, revealed LPN #3 administered one puff of Symbicort Inhaler (corticosteroid for COPD) by oral inhalation and after five minutes administered another puff to resident #35.</p> <p>Further observation revealed Resident #35 did not rinse the mouth with water after the administration of the two puffs of the Symbicort Inhaler.</p>	F 332			

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F 332	<p>Continued From page 8</p> <p>Medical record review of the signed physician orders dated October 4, 2010, for resident #35 revealed an order for "...SYMBICORT 80/4.5 INHALE 2 PUFFS BID (twice daily)..."</p> <p>Review of the manufacturer's specification in the Inhaled Medications guide from the American Society of Consultant Pharmacists (MED-PASS) revealed under Corticosteroid (Symbicort) Inhalers to "...Rinse mouth after each use (do not swallow the rinse water) to help prevent oropharyngeal fungal infections..."</p> <p>Interview with LPN #3 on October 26, 2010, at 10:00 a.m., at the 300 Hall Nursing Station, confirmed one medication error occurred when the resident did not rinse the mouth with water after the administration of two puffs of the Symbicort Inhaler.</p> <p>Medication Error #5</p> <p>Observation on October 26, 2010, at 8:23 a.m., at the 300 Hall Cart, revealed LPN #3 administered one 5 ml dose of Guaifenesin 100 mg (expectorant) and Dextromethorphan 10 mg (cough suppressant) by mouth to resident #35.</p> <p>Medical record review of the signed physician orders dated October 4, 2010, for resident #35 revealed an order for "...GUAIFENESIN 100 mg PO Q DAY..."</p> <p>Interview with LPN #3 on October 26, 2010, at 10:00 a.m., at the 300 Hall Nursing Station, confirmed one medication error occurred when the resident was administered one dose of Guaifenesin with Dextromethorphan instead of one dose of Guaifenesin.</p>	F 332			

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F 332	Continued From page 9 Medication Error #6 Observation on October 26, 2010, at 8:51 a.m., at the 200 Hall Cart, revealed LPN #4 administered one dose of Omeprazole 20 mg capsule for indigestion to resident #34. Medical record review of the signed physician orders dated September 28, 2010, for resident #34 revealed an order for "...PRILOSEC (OMEPRAZOLE) 20 MG PO Q 6 AM (INDIGESTION) **DO NOT CRUSH**..." Review of the manufacturer's specification for the administration of Omeprazole in the Geriatric Dosage Handbook Fourteenth Edition Page 1199 revealed under Patient Information to "...Take before eating..." Interview with LPN #4 on October 26, 2010, at 9:13 a.m., at the 200 Hall Nursing Station, confirmed one medication error occurred when the Omeprazole 20 mg was administered after breakfast and not at 6 a.m., (before breakfast) per physician orders. Interview with the Nutritional Service Manager on October 26, 2010, at 12:45 p.m., in the DON office confirmed the breakfast trays for the 200 Hall are served between 7:30 a.m., and 7:45 a.m., daily. The Omeprazole 20 mg capsule was administered approximately 90 minutes after breakfast was served.	F 332			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431			

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F 431	<p>Continued From page 10</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility shift to shift control drug reconciliation records on two medication carts (100 Hall medication cart and 600 Hall medication cart) of eight medication carts, facility policy, and interview, the facility</p>	F 431	<p><u>F-431 Drug Records, Label/Store Drugs & Biologicals/rinary Incontinence</u></p> <ol style="list-style-type: none"> 100 Wing and 600 Wing's Narcotic Count sheets were reconciled on 10/27/2010. 6 wings have the potential to be affected by the same deficient practice. All 6 Narcotic Count sheets (1 per wing) were reconciled on 10/27/2010. Assistant Director of Nursing and/or Admission Nurse will inservice licensed nurses on Reconciliation of Tracking Log for Controlled Substances, Controlled Substances, and Controlled Substance Count Sheets. Completion Date: 11/30/2010 RN Supervisors and/or Admission Nurse will randomly audit 6 wings for compliance 5 x week x 1 week, 3 x week x 1 week, 2 x week x 2 weeks for a total of 4 weeks of audits. Quality Assurance Committee will review audits during regularly scheduled meetings to evaluate findings and amend plan as necessary. Completion date: 11/30/2010 	11/30/10	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/27/2010
NAME OF PROVIDER OR SUPPLIER HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 11</p> <p>failed to establish a system of records of disposition of control drugs in sufficient detail to enable an accurate reconciliation shift to shift.</p> <p>The findings included:</p> <p>100 Hall Cart</p> <p>Observation on October 26, 2010, at 3:11 p.m., on the 100 Hall medication cart revealed 31 individual Narcotic Count Sheets logged on the 100 Hall medication cart Controlled Drug Tracking Log and 34 individual Narcotic Count Sheets with the Medication Administration Records (MAR) on the 100 Hall medication cart.</p> <p>Review of 34 individual Narcotic Count Sheets revealed 3 individual Narcotic Count Sheets were not logged on the 100 Hall cart Controlled Drug Tracking Log.</p> <p>Further review revealed the narcotic reconciliation on the shift to shift (narcotic) count record was documented as "exact" at the change of the shift on October 26, 2010, at 6:30 a.m.</p> <p>Review of facility policy revealed, "... (During shift-to-shift counts via (by way of) two nurses, Tracking Log, controlled substances and count sheets are all reconciled)..."</p> <p>Interview on October 26, 2010, at 4:10 p.m., at the 100 Hall cart with LPN #5 confirmed 3 individual Narcotic Count Sheets were not logged onto the 100 Hall cart Controlled Drug Tracking Log and the shift to shift reconciliation on October 26, 2010, at 6:30 a.m., was inaccurate.</p> <p>600 Hall Cart</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 431	<p>Continued From page 12</p> <p>Observation on October 26, 2010, at 4:45 p.m., on the 600 Hall medication cart revealed 57 individual Narcotic Count Sheets logged on the 600 Hall medication cart Controlled Drug Tracking Log and 53 individual Narcotic Count Sheets with the MARs on the 600 Hall medication cart.</p> <p>Review of the 57 individual Narcotic Count Sheets logged onto the Controlled Drug Tracking Log revealed 5 individual Narcotic Count Sheets were missing on the 600 Hall medication cart.</p> <p>Further review of the 53 individual Narcotic Count Sheets on the 600 Hall medication cart revealed 1 individual Narcotic Count Sheet was not logged on the Controlled Drug Tracking Log.</p> <p>Further review revealed the narcotic reconciliation on the shift to shift (narcotic) count record was documented as "exact" at the change of the shift on October 26, 2010, at 2:30 p.m.</p> <p>Review of facility policy revealed, "... (During shift-to-shift counts via (by way of) two nurses, Tracking Log, controlled substances and count sheets are all reconciled)..."</p> <p>Interview on October 26, 2010, at 6:05 p.m., at the 600 Hall cart with LPN #5 confirmed 5 individual Narcotic Count Sheets were missing on the 600 Hall medication cart; one individual Narcotic Count Sheet was not logged on the 600 Hall medication cart Controlled Drug Tracking Log; and the shift to shift reconciliation at 2:30 p.m. on October 26, 2010, was inaccurate.</p> <p>Interview on October 27, 2010, at 1:30 p.m., in</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER HOLSTON MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3641 MEMORIAL BLVD KINGSPORT, TN 37664		
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F 431	Continued From page 13 the Director of Nursing (DON) Office with the DON, Corporate Nurse, and LPN #5 confirmed the discrepancies with control substance shift to shift reconciliation on two of eight medication carts.	F 431			